CONCUSSION QUESTIONNAIRE

PATIENT: _____ DATE: _____

DATE OF ACCIDENT: _____

Please check any of the following boxes that correspond to any symptom(s) that you have had recently since your neck or head injury.

YES	SYMPTOM
☐	Headaches
☐	Loss of coordination
☐	Reduced drive/motivation
☐	Poor memory
☐	Difficulty finishing tasks
☐	Sleep disorders
☐	Abnormal levels of anxiety
☐	Reduced tolerance to alcohol
☐	More assertive
☐	Forgetful
☐	Anger outbursts
☐	Depression
☐	Fatigue
☐	Absence of ability to anticipate
☐	Inflexibility
☐	Impaired sexual function
☐	Language difficulty
☐	Impaired judgment
☐	Need daytimer to remember home and/or work activities
☐	Blurry vision
☐	Loss of balance
☐	Difficulty handling multiple tasks
☐	Dizziness/lightheadedness
☐	Irritability
☐	Personality change
☐	Hand tremors
☐	Ringing in ears
☐	Less diplomatic than normal
☐	Mood swings
☐	Reduced attention span
☐	Blackouts
☐	Indifference to other people
☐	More shallow relationships
☐	Difficulty with problem solving
☐	Less mental stamina
☐	Performance inconsistencies
☐	Verbal learning problems
☐	Slower reaction times